In the Supreme Court

of the United States

OCTOBER TERM, 1976

No. 76-859

HAZELWOOD CHRONIC & CONVALESCENT HOSPITAL, INC., dba KEARNEY STREET CONVALESCENT CENTER,

Petitioner,

v.

CASPER WEINBERGER, SECRETARY OF HEALTH, EDUCATION AND WELFARE, THE UNITED STATES OF AMERICA, and BLUE CROSS OF OREGON, dba NORTHWEST HOSPITAL SERVICE,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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Petitioners pray that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The United States Court of Appeals for the Ninth Circuit, on September 23, 1976 (Appendix, p. A8), reversed the judgment of the United States District Court for the District of Oregon and remanded for

entry of judgment in favor of the respondents. The judgment of the United States District Court for the District of Oregon was not published as a reported opinion but is part of the record of this case in the findings of fact and conclusions of law entered (Appendix, p. A1).

JURISDICTION

The judgment of the United States Court of Appeals for the Ninth Circuit was entered on the 23rd day of September, 1976. The jurisdiction of this Court rests on 28 U.S.C. § 1254.

QUESTIONS PRESENTED

1. May the Secretary of Health, Education and Welfare constitutionally and lawfully recapture reimbursements for Medicare program participation ex post facto?

2. Was the retroactive application of the Medicare regulation applied to the petitioner in this case so unexpected, disruptive, harsh and oppressive that constitutional limitations were exceeded?

3. May the Secretary promulgate a regulation purportedly under the authority of a statutory grant of rule-making power, without making the factual findings required by the statute as a prerequisite to rule-making?

4. Did the Congress countenance a procedure which would permit the Secretary of Health, Education and

Welfare at any time to reopen final determinations of Medicare payments to which the petitioner may have been entitled years before the determinations reopened?

5. Is the Secretary of Health, Education and Welfare, pursuant to his own regulations, limited to making such "suitable retroactive corrective adjustments" as are limited to the end of a fiscal year or accounting period?

6. Does not the decision of the Court of Appeals for the Ninth Circuit, to which this Petition for Writ of Certiorari is addressed, incorrectly state the controlling Constitutional principle, in contrast to the correct statement of those Constitutional principles by the United States Court of Appeals for the Fifth Circuit?[1]

7. Does the decision of the United States Court of Appeals for the Ninth Circuit, to which this Petition for a Writ of Certiorari is addressed, incorrectly state the proper interpretations of the controlling statutes and regulations, in conflict with the decisions of the United States Courts of Appeals for the Second and Fifth Circuits and the United States Court of Claims?[2]

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[1] See *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger and Blue Cross of Florida, Inc.*, 376 F. Supp. 1099, 1127-1129 (S.D. Fla. 1974); 517 F.2d 329, 335 (5th Cir. 1975); see also *Columbia Heights Nursing Home & Hospital, Inc.* v. *Weinberger*, 380 F. Supp. 1066, 1072 (M.D. La. 1974); *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F. Supp. 646 (S.D. Fla. 1972).

[2] See *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973); *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger & Blue Cross of Florida, Inc.*, footnote 1 supra; *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct. Cl. 1976).

CONSTITUTIONAL PROVISION INVOLVED

The Due Process Clause of the Fifth Amendment provides:

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb, nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATUTORY PROVISION INVOLVED

42 U.S.C. § 1395x(v)(1)(A), 42 U.S.C.A. pp. 493-4 (1974) (text reproduced in Appendix, p. A22).

REGULATION INVOLVED

20 C.F.R. 405.415(d)(3), 20 C.F.R. p. 459 (1976) (text reproduced in Appendix, p. A24).

STATEMENT OF THE CASE

Petitioner was a qualified Medicare provider of services, effective January 1, 1967. Medicare regulations then were a part of the contract which the petitioner entered into with the respondents. That con-

tract authorized petitioner to accelerate depreciation of qualified assets, as an inducement to enter the Medicare program and allowed withdrawal from the program without qualification or penalty. Those accelerated depreciation charges were an allowable cost item, as an integral part of the plaintiff's participation in the Medicare provisions. Petitioner's accelerated depreciation charges were regularly reported and properly filed, in timely fashion, each year through 1971, when the petitioner voluntarily terminated its participation as a Medicare provider.

On October 1, 1970, the Secretary adopted a regulation providing for retroactive recapture of accelerated depreciation used by a provider of services, should that provider decide to leave the program.

On October 12, 1972, the Secretary applied the provisions of the Medicare regulation in question[3] and recomputed from an accelerated to a straightline basis the depreciation charges reimbursed to the petitioner from January 1, 1967, to December 1, 1971. Thus, five years after the fact, the respondents' agents notified the petitioner that alleged "excess reimbursements" would be recovered from the petitioner. Six years after the fact, the Secretary began recovering those "excess reimbursements."

The statutory scheme requires the Secretary of Health, Education and Welfare to promulgate such Medicare regulations as will reimburse the providers of Medicare services for the actual costs of pro-

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[3] 20 C.F.R. 405.415(d)(3).

viding Medicare services for a given fiscal period. The accelerated method of computing depreciation presumes that the usefulness of capital assets is depleted at a faster rate in earlier years than in later years. The statutory standard is one of "actual cost." In 1966, when the Secretary authorized the use of accelerated depreciation, he necessarily found that this depreciation method approximated actual capital asset depletion for any given fiscal period. In 1970, however, the Secretary promulgated the challenged depreciation recapture regulation without ever making a finding that accelerated depreciation charges yielded excessive reimbursements to Medicare providers for any given fiscal period.

The Medicare Act in addition required the Secretary to pay, as closely as possible, the *actual costs* of each provider's Medicare operations.[4] The record makes no showing in this case that the petitioner's accelerated depreciation reimbursements were anything other than petitioner's actual rate of loss of value of capital assets.

Jurisdiction in the Court of the first instance was based upon the existence of a federal question. See 28 U.S.C. § 1331.

The petitioner sought from the Court of first instance a declaratory judgment that the Medicare regulation in question was unconstitutional and its application to the petitioner was both unconstitutional and beyond the statutory authority; the petitioner also

[4] 42 U.S.C. § 1395f(b) (1970).

sought a permanent injunction against the enforcement of that regulation upon the petitioner and the recovery of moneys withheld pursuant to that regulation by the respondent. The U. S. District Court for the District of Oregon held that the respondents' recapture of depreciation charges taken by the petitioner prior to January 1, 1970, was both unconstitutional and unlawful, enjoined the application of the regulation as to the petitioner for that period of time preceding January 1, 1970, and awarded a money judgment to the petitioner for the sums already recovered by the respondents prior to January 1, 1970.

REASONS FOR GRANTING THE WRIT

I

The decision of the Court of Appeals below is in conflict with the decisions of other Courts of Appeals.

II

The decision of the Court of Appeals below incorrectly speaks to an important question of federal law which has not been settled by this Court, in the interpretation of the statutory operation of the Medicare provisions.

III

The decision of the Court of Appeals below conflicts with the applicable decisions of this Court on the constitutionality of retroactive administrative impairment of contract rights, as well as on the Due

Process limitations on retroactive deprivation of property.

ARGUMENT

I

Conflicts Among the Circuits

The decision of the United States Court of Appeals for the Ninth Circuit below holds that in the application of the Medicare laws the Secretary of Health, Education and Welfare may skip beyond a provider's current fiscal period and recompute the provider's earned and received contract payments for its entire period of Medicare participation. The United States Court of Appeals for the Second Circuit, the United States Court of Appeals for the Fifth Circuit and the United States Court of Claims have held that such action by the Secretary is not countenanced by law.

The Second Circuit, in *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663, 670 (1973), confronted a Secretary of Health, Education and Welfare who was refusing to reopen earlier accounting periods, lest retroactivity be applied without suitable limitations. The Secretary then urged the Court of Appeals to consider the hardships that would prevail if all reimbursements remained forever subject to adjustment. The Court of Appeals agreed. That policy consideration would dictate a regulation limiting the extent of retroactivity of "corrective adjusting regulations."

The Fifth Circuit, in *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F.2d 329, 335 (1975); Cert. Den. 96 S. Ct. 1665 (April 19, 1976) specifically endorsed that portion of the decision of the U. S. District Court for the Southern District of Florida in the lower Court opinion, 376 F. Supp. 1099, 1129 (1974) as having correctly analyzed the Medicare statutes here involved. That District Court opinion concluded that the retroactive cost adjustment procedures authorized by the statutes (see 42 U.S.C. § 1395 x(v)(1)(A)) were limited by their terms to the current fiscal period. The Secretary in the adopted regulations, 20 C.F.R. § 405.405(c), limited retroactivity to the end of the accounting period. As the Fifth Circuit Court of Appeals noted: "Congress chose to pay providers only the 'reasonable cost' of services, *to be determined at the end of each fiscal year.*" (Emphasis supplied) 517 F.2d 329 at 335.

In the United States Court of Claims, the government contended that the provisions for suitable retroactive corrective adjustments in the Medicare laws called only for annual adjustments at year end. *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 352 (1976). The Court of Claims found that the Secretary is required to permit a provider of services to recover actual costs rather than accept inadequate reimbursements. By a parity of reasoning, the Secretary cannot recoup former reimbursements on the allegation that they were excessive, without proof. In our case the Secretary made no effort to establish such proof.

II

The Federal Statutory Scheme Unsettled

What is a "fiscal period" for Medicare providers of service? The term, "fiscal period," or "cost-reporting period," or "accounting period," as the concept is variously designated, recurs throughout the Medicare statutory and regulatory provisions.[5] The Court of

[5] See, e.g., 42 U.S.C. 1395x(v)(1)(B) "the rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period . . ."; 20 C.F.R. 405.420(f) "the amounts uncollectible for specific beneficiaries are to be charged off as bad debt in the accounting period in which the accounts are deemed to be worthless"; 20 C.F.R. 405.425(c) "when they are received in the same accounting period in which the purchases were made or the expenses were incurred . . ."; 20 C.F.R. 405.429(b)(2) "for purposs of computing the allowable return the amount of equity capital is the average investment during the reporting period"; 20 C.F.R. 405.430 "an inpatient routine nursing salary cost differential is allowable as a reimbursable cost of a provider after June 30, 1967, and before that provider's first cost-reporting period which begins after June 1975"; 405.432(b)(5) "this determination shall be made by dividing the total hours of service furnished during the cost reporting period . . ."; 20 C.F.R. 405.451 "however, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on . . ."; 20 C.F.R. 405.452(e)(1)(ii) "the cost of services to beneficiaries of the health insurance program may, for cost reporting periods starting before January 1, 1972, be determined by either of the alternative methods that is selected by a provider"; 20 C.F.R. 405.453(d) "after the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual costs of services rendered during that period"; 20 C.F.R. 405.454(a) "a retroactive adjustment based on actual costs will be made at the end of the reporting period"; 20 C.F.R. 405.454(f)(3) "to determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for the reporting year is computed . . ."; 20 C.F.R. 405.455(d)(2) "a new provider of services may carry forward for five succeeding cost reporting periods. . . ."

Appeals for the Ninth Circuit below found that a fiscal period is any span of time which the Secretary wants the fiscal period to represent, when the Secretary seeks to recover past reimbursements. The Court of Appeals for the Fifth Circuit finds that a fiscal period is that accounting or reporting period adopted by the Secretary and the provider of services. The Second Circuit agrees.[6] What limitation is there on the Secretary's right or authority to make retroactive adjustments? In years? In fiscal periods? On accounting principles? On economic theories?

The statute by its own terms limits any retroactive corrective regulation to a "fiscal period." 42 U.S.C. 1395x(v)(1)(A). At the time the statute was enacted, both Congress and the Department of Health, Education and Welfare agreed that the statute would not permit the Secretary to enact a corrective regulation retroactive beyond the beginning of the provider's current fiscal period.[7] The Second and Fifth Circuits

[6] *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger and Blue Cross of Florida, Inc., supra; Kingsbrook Jewish Medical Center* v. *Richardson, supra,* footnote 2.

[7] Reimbursement Guidelines for Medicare, Hearings before the Senate Committee on Finance (89th Congress, Second Session) May 25, 1966, p. 119:

"Senator ANDERSON: What does the law require?

"Mr. BALL [Commissioner of Social Security]: That we pay cost.

Senator ANDERSON: If you find out you haven't paid cost—you have to pay it then. Why don't you find out about it?

Mr. BALL: I don't think that the retroactive provision [42 U.S.C. § 1395x(v)] contemplates going back over the year and changing the principles. I think what is contemplated is that you pay first on the basis of advances, that is estimates — not advances — an estimate —

agreed. See footnote 2, *supra*. The Ninth Circuit disregards the limitation recognized by the statutory language, understood both by Congress and the administrative agency, and recognized by the Second and Fifth Circuits.

When is a final "settlement" final, for the Medicare provisions? The dissenting opinion from the Court of Appeals for the Ninth Circuit below opined that a final settlement should be a final settlement, as the regulations provided, at the end of an accounting period. By implication, the majority in the United States Court of Appeals for the Ninth Circuit below would disagree. The Fifth Circuit would be in agreement with the dissenting opinion below, in disagreement with the majority opinion below.[8] Arguably the Second Circuit does agree with the majority opinion in the Court of Appeals for the Ninth Circuit below, on the issue of when finality is finality. Arguably as well the Court of Claims agrees with the majority in the Ninth Circuit, disagrees with the dissent in the

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Senator ANDERSON: No, 'advance' is all right. I follow you.
Mr. BALL: We have changed that. That is not an advance. But you make an estimate at the beginning of the year on the basis of these principles. Then at the end of the year you settle up, on the basis of the principles put out.
It would hardly seem reasonable at the end of the year, after hospitals had entered into an agreement with you on the basis of certain principles, to shift all the principles for retroactive settlement in terms of how you compute a cost. I don't think that was contemplated at all."

[8] *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger and Blue Cross of Florida, Inc., supra,* footnote 2.

Ninth Circuit, in the case below, and disagrees with the determination of the Fifth Circuit.[9]

The Ninth Circuit decision renders meaningless two provisions in the enabling statute under which the regulation purportedly was authorized:

> First, in order to protect providers from the exact type of arbitrary administrative action encountered by petitioner, Congress specified that retroactive corrective regulations be promulgated *only* after the Secretary makes findings that a particular cost accounting method has produced inaccurate reimbursements. Indeed, the Secretary's actions in *Kingsbrook* (footnote 2, *supra)* in making such findings and in then failing to promulgate a corrective regulation based on those findings set the context of the *Kingsbrook* holding. See p. 8, *supra*. In contrast, the Secretary has made absolutely no showing that the prerequisite findings were made to support the depreciation recapture regulation before this Court now.
>
> Secondly, Congress limited the Secretary's retroactive regulatory authority to instances in which a *method of computing costs* created inaccurate reimbursements. Thus, a valid regulation would be triggered by, and would focus on, the method of accounting used by providers, and would "correct" that method for *all* providers using the method. The present regulation, by contrast, dictates that the accelerated method of depreciating

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[9] See *Whitecliff* v. *United States, supra,* footnote 2.

> assets is allowable for providers continuing in the program (and the current regulations continue to recognize that method of depreciation) while not allowable for those who, however briefly, have terminated program participation. The challenged regulation focuses upon, and is triggered by, the *act of termination* and not by an "inaccurate method of computing costs." Congress simply did not authorize the Secretary to penalize a provider's choice to leave the program.

Congress clearly did not intend to perform useless acts in placing these two restrictions into the statute. Yet the Ninth Circuit edits those limits from the statute by its decision.

Each of the issues here — the constitutionality and statutory validity of the depreciation recapture regulation, the necessity of the Secretary's making required statutory findings — are important issues of Federal law. Social concern for adequate medical care for the aged is nationwide, current and of growing intensity; the manner in which the Medicare Act is administered and applied to providers has a direct relationship to the amount (and the quality) of medical care provided. The precise issue of the validity of this depreciation regulation currently poses perplexing and unsettled questions for a substantial number of courts nationwide,[10] involving millions of dollars. Literally

[10] Cases currently pending involving the validity of this depreciation recapture regulation include: *Adams Nursing Home* v. *Matthews* (1 Cir. No. 76-1212); *Springdale Nursing Home* v. *Matthews* (5 Cir. No. 75-4199); *Rio Hondo Memorial Hospital* v. *Weinberger* (9 Cir. No. 75-3482); *South Windsor Convalescent Home* v. *Matthews*, (2 Cir. No. 75-6136, dismissed July 27, 1976 with instructions to refile with the Court of Claims); *The Summit Nursing Home* v. *United States* (Ct. Cl. No. 89-74); *EGH-MHB Enterprises* v. *Matthews* (N.D. Cal. No. C-76-1026); *Parkview Nursing Home* v. *Matthews* (S.D. Ind. No. IP 75-686-C, notice of appeal filed from judgment for provider rendered Oct. 5, 1976); *Chicora Medical Center* v. *Matthews* (W.D. Pa. No. 76-1556); *United States* v. *National Living Centers, Inc.* (S.D. Tex. No. 75-H-760); *Miller Rutledge Corp.* v. *United States* (Ct. Cl. No. 147-75); *Urbana Americana* v. *United States* (Ct. Cl. No. 148-75); *Lincoln Park Nursing Home* v. *Weinberger* (D. N.J. No. 74-1431).

dozens of providers similarly situated nationwide either are "locked into" the Medicare system in fear of having this regulation applied upon termination of participation, or have terminated their participation and await the threat of possible recapture of funds received years ago and long since spent for medical services.

Moreover, the issues in the instant case require a determination of the extent to which an administrative agency must make statutory-mandated findings before taking regulatory action; that question pervades all Federal administrative action. Supreme Court cognizance and disposition of the issue in the present Medicare context will have effects reaching through the administration and provision of medical services to the administrative implementation of Congressional mandates.

The inequity, and the statutory invalidity, of the Secretary's actions as sanctioned by the Ninth Circuit clearly appears by comparing the Secretary's position in *Kingsbrook, supra,* with the Secretary's

position concerning the present regulation. In *Kingsbrook*, the Secretary urged, and the Second Circuit agreed, that *limited* retroactivity was mandated by the statute; there the Government consistently had underpaid providers. Yet when the Secretary suspects, without findings or proof, that providers were being overpaid by previously-approved depreciation methods, the Secretary (with the blessings of the Ninth Circuit) insists that full and complete recomputation is required, with unlimited backward reach. Statutory reregulation should not be permitted to vary with the Secretary's guess of underpayment or overpayment; the Ninth Circuit opinion below places its *imprimatur* on this Federal lack of evenhandedness.

III

Ex Post Facto Impairment of Contract Obligations Does Violence to the Due Process Clause of the Fifth Amendment

The Courts are well instructed to avoid finding constitutional infirmities, if statutory corrections can be supplied by judicial interpolation. Thus, in *Columbia Heights Nursing Home & Hospital, Inc.* v. *Weinberger*, 380 F. Supp. 1066 (M.D. La. 1974) the Court made every effort to read fairly the Secretary's regulations for suitable retroactive corrective adjustments. On a fair reading of those regulations the Court would not justify the conclusion, urged by the Secretary, that new and different basic accounting procedures could be implemented on a retroactive basis, to result in substantial increases or decreases in reim-

bursable costs to medical service providers, under the Medicare laws. 380 F. Supp. at 1071. The Court's hackles bristled. Where there was no clear statutory authority for the retroactive application of the new accounting procedures adopted by the Secretary's representatives, allowing that kind of retroactive action would be "grossly unfair, terribly unjust, and . . . denied." *Ibid.*, p. 1072. That says in declarative terms what the Constitution mandates.

A Medicare provider's right to reimbursement for costs incurred in providing Medicare services is in the nature of an earned property right for which the Due Process Clause provides protection, *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F. Supp. 646, 650 (S.D. Fla. 1972). Respondents do not deny that petitioner rendered such services during the periods at issue, nor does the Government deny that reimbursements for accelerated depreciation charges taken during those periods were properly payable to petitioner under the existing regulations.

Retroactive regulations are those which "take away or impair a vested right acquired under existing laws or create a new obligation or impose a new duty or attach a new disability in respect to transactions or considerations already past." *Vail* v. *Denver Building & Construction Trades Council*, 115 P.2d 389, 393 (Colo. 1941). While not all retroactive enactments are void, those enactments violate the Due Process Clause which impair rights "which can truly be said to be *vested* rights of a nature constituting

property rights." *Seese* v. *Bethlehem Steel Company*, 74 F. Supp. 412, 417 (D. Md. 1947).

In *United States* v. *Hudson*, 299 U.S. 498, 500 (1937), this Court recognized that Congress had the authority to create a limited period of retroactivity for income tax legislation consistent with the Due Process Clause:

> "As respects income tax statutes, it long has been the practice of Congress to make them retroactive for relatively short periods so as to include profits from transactions consummated while the statute was in process of enactment, or within so much of the calendar year as preceded the enactment; and repeated decisions of this Court have recognized this practice and sustained it as consistent with the due process of law clause of the Constitution."

The "recent transactions" test has been consistently applied, and constitutes a standard under which the present Medicare regulation cannot be countenanced.

There was no way in which petitioner had any opportunity to avoid the retroactive effect of this regulation, once the Secretary adopted it. Petitioner could hope that the regulation would not be applied contrary to statute or contrary to the Constitution, or contrary to the terms of the regulation itself. Petitioner could not have insisted on its termination from the Medicare program prior to the effective date of the regulation in question.

Now it may be taken as settled law that regulations whose retroactive effect is either harsh or oppressive necessarily violate due process, the sense of what is fair, disturbing the conscience of the commonweal. Both the record in this case and the applicable authorities support the conclusion that the depreciation recapture regulation as applied to the petitioner here transgresses Constitutional limitations.

In the simplest sense, Medicare laws provide compensation for services rendered. See *Coral Gables Convalescent Home, Inç.* v. *Richardson, supra.* The measure of that compensation is specified by regulation, rather than by explicit contractual provisions for each Medicare servant. It is only as a result of the contractual relationship between the petitioner and the respondent that the regulatory power of the Secretary is visited upon the petitioner. That is the reason for protecting the petitioner's rights against the United States, arising out of this contract, under the aegis of the Fifth Amendment of the U. S. Constitution. There the Due Process Clause prohibits the contracting party, the Secretary, for the United States, from annulling contractual rights of the petitioner. See *Lynch* v. *United States*, 292 U.S. 571, 579 (1934). The petitioner's contract rights have been, to say the least, "impaired." When the value of the contract has been diminished by subsequent legislation, then the question of impairment is not one of degree, like a little bit of pregnancy. See *Rorick* v. *Board of Commissioners*, 57 F.2d 1048, 1055 (5th Cir. 1932).

CONCLUSION

The petitioner entered the Medicare program knowing that the Secretary had passed cost reimbursement regulations, as required by statute, to square with the actual costs incurred by a provider of medical services. There was no way in which the petitioner could have anticipated that the Secretary would attempt to reach, by retroactive regulation, back, several years, into old programs, carefully calculated, tightly budgeted and strictly funded. The Secretary's incursion into such ex post facto rule-making stepped beyond what the Constitution would permit.

The Ninth Circuit Court of Appeals in the decision on this case below has taken its stand in contravention of the positions announced by other Courts of Appeals and the Court of Claims. That conflict among the Circuits should be resolved, in order to set at rest any suspicion that the judgment below properly reflects the statutory interpretation of the Medicare provisions and their constitutionality as applied to such as the petitioner here.

The petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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ARDEN E. SHENKER
MICHAEL J. GENTRY
Counsel for Petitioner

(December 17, 1976)

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

HAZELWOOD CHRONIC & CONVALESCENT HOSPITAL, INC., dba KEARNEY STREET CONVALESCENT CENTER, Plaintiff	CIVIL NO. 73-210
vs.	
CASPER WEINBERGER, SECRETARY OF HEALTH, EDUCATION AND WELFARE, THE UNITED STATES OF AMERICA; AND BLUE CROSS OF OREGON, dba NORTHWEST HOSPITAL SERVICE, Defendants.	FINDINGS OF FACT, CONCLUSIONS OF LAW

This matter having been submitted for determination on January 4, 1974, the plaintiff was represented by Arden E. Shenker and Michael J. Gentry, the defendants were represented by Vinita Jo Neal, the Court, having examined the files and record, heard oral argument. The Court makes the following findings of fact and conclusions of law, and renders the following order:

FINDINGS OF FACT

1. Plaintiff is an Oregon corporation with its principal place of business in Oregon.

2. Defendant Northwest Hospital Service, dba Blue Cross of Oregon (hereinafter "Blue Cross") is an Oregon corporation with its principal place of business in Oregon.

3. Defendant Casper Weinberger (hereinafter "Secretary") has his official residence in the District of Columbia and is the Secretary of Health, Education and Welfare of the United States of America. Defendant Secretary is sued solely in his official capacity.

4. The amount in controversy exceeds $10,000 exclusive of interest and costs.

5. Title XVII of the Social Security Act, 42 U.S.C. § 1395 *et seq* (hereinafter "Medicare Program") provides a system for reimbursing qualified individuals for part of the costs they incur for covered health care. In some cases, the Medicare Program authorizes payment to be made to providers of services on behalf of such individuals.

6. The Medicare Program further authorizes defendant Secretary to agree with private organizations designated as "intermediaries" to compute and administer payments to providers of services.

7. As of January 1, 1967, the Secretary accepted for filing plaintiff's agreement under Section 1866 of the Social Security Act (42 U.S.C. § 1395cc(a)) and thus became qualified as a provider of services.

8. On December 1, 1971, plaintiff voluntarily terminated its agreement to be a provider of services in the Medicare Program.

9. As of July 1972, plaintiff again qualified and became a provider with the predecessor-in-office of defendant Secretary to provide Medicare services, and presently continues to provide services.

10. Blue Cross Association (BCA) entered into an agreement to act as an intermediary with the Social Security Administration pursuant to the provisions of Section 1816 of the Social Security Act to perform for the Secretary designated functions in the administration of regulation of the Medicare Program.

11. Blue Cross Association delegated its duties (under Section 1816 and 1842 of the Social Security Act) as a fiscal intermediary for Hazelwood to Blue Cross of Oregon, one of its local plan organizations under subcontract with Blue Cross Association. By reason of such subcontract, Blue Cross of Oregon became the fiscal intermediary for Hazelwood and through such intermediary the Secretary made payments and continues to make payments under the Medicare Program to Hazelwood.

12. As a participating provider of services under the Medicare Program, Hazelwood is required to file cost reports with the intermediary pursuant to 20 C.F.R. 405.406(b) so that the latter can determine "reasonable cost" of furnishing services to Medicare beneficiaries.

13. Reimbursement of providers under the Medicare Program is based on the concept of "reasonable cost" as set forth in 42 U.S.C. § 1395(x)(v).

14. At all times between January 1, 1967 and December 1, 1971, accelerated depreciation charges taken by plaintiff on its health care facilities were specifically recognized in the Medicare regulations as items of "reasonable cost."

15. Plaintiff received reimbursement of its "reasonable cost" for Medicare Program participation between January 1, 1967 and December 1, 1971, including reimbursement for accelerated depreciation charges.

16. Prior to August 1, 1970, the Medicare regulations neither qualified a provider's use of accelerated depreciation nor provided for recapture of any portion of accelerated depreciation charges taken by a provider.

17. The Medicare regulations currently recognize accelerated depreciation as a reimbursable item of "reasonable cost" for providers whose current participation began prior to August 1, 1970.

18. Section 1861(v) of the Social Security Act, 42 U.S.C. § 1395(x)(v), authorizes the Secretary to promulgate regulations defining items of reimbursable reasonable cost and further provides that such regulations shall:

> "1) . . . (B) provide for the making of suitable retrocative (sic) corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs he proves to be either inadequate or excessive."

19. The predecessor-in-office of defendant Secretary promulgated an administrative regulation, effective August 1, 1970, published in 35 FR 2593 on February 5, 1970, which in relevant part reads as follows:

> "When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, . . . the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an off-set to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment."

Blue Cross of Oregon, on October 12, 1972, in applying this regulation, retroactively offset depreciation expense computed on an accelerated method over the reimbursable cost which would have been determined and paid under the program by using a straight-line method of depreciation for the period January 1, 1967, to December 1, 1971.

20. On January 17, 1973, defendant Blue Cross told plaintiff that Blue Cross would apply the above regulation to plaintiff, and that under the regulation plaintiff's excess reimbursable cost totaled $24,678. By this same letter Blue Cross notified plaintiff of available appeal procedures.

21. Blue Cross Association, under its contract with the Secretary, is required to establish and maintain such procedure as the Secretary may approve for considering and resolving any dispute arising between a provider of services and the Blue Cross Plan serving as intermediary. Blue Cross Association has estab-

lished a Provider Appeals Committee to receive and hear appeals from providers dissatisfied with intermediaries' determinations.

22. On February 9, 1973, defendant Blue Cross notified plaintiff that plaintiff's current Medicare reimbursements would be reduced by $2,742 per month for nine months beginning March 6, 1973 to recover the above amount.

23. Plaintiff's monthly reimbursements have been reduced by $2,742 per month by defendant Blue Cross.

24. On or about June 5, 1973, plaintiff requested a hearing on the decision of Blue Cross of Oregon regarding recoupment. This request is still pending.

25. All notices of Medicare Program reimbursement for plaintiff's program years 1967 and 1968 were received by the plaintiff prior to October 12, 1969.

CONCLUSIONS OF LAW

1. Medicare regulation 20 CFR 405.415(d)(3) is unconstitutional under the due process clause of the Fifth Amendment of the United States Constitution, to the extent that the regulation authorizes recapture of reimbursements for depreciation charges taken prior to the beginning of the year in which such regulation was promulgated.

2. Medicare regulation 20 CFR 405.415(d)(3), as applied to plaintiff to recapture reimbursements for depreciation charges taken by plaintiff prior to

January 1, 1970, is unconstitutional under the due process clause of the Fifth Amendment of the United States Constitution.

3. Defendants may not lawfully recapture reimbursements for depreciation charges taken by plaintiff from January 1, 1967 through December 31, 1969.

4. Medicare regulation 20 CFR 405.415(d)(3), is constitutional as applied to recapture reimbursements for depreciation charges taken by plaintiff subsequent to December 31, 1969.

DATED this 1st day of February, 1974.

Gus J. Solomon
U. S. District Judge

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

HAZELWOOD CHRONIC & CONVALESCENT HOSPITAL, INC., dba KEARNEY STREET CONVALESCENT CENTER,
Plaintiff-Appellee,
vs.
CASPAR [sic] WEINBERGER, SECRETARY OF HEALTH, EDUCATION AND WELFARE THE UNITED STATES OF AMERICA, AND BLUE CROSS OF OREGON, dba NORTHWEST HOSPITAL SERVICE,
Defendants-Appellants.

No. 74-2210

OPINION

[September 23, 1976]

On Appeal from the United States District Court
for the District of Oregon

Before: WALLACE and KENNEDY, Circuit Judges, and FERGUSON,* District Judge.

KENNEDY, Circuit Judge:

In this case we consider the effect of 42 U.S.C. § 405(h) in precluding district court jurisdiction to review a decision of the Secretary of Health, Education, and Welfare regarding payments to a hospital under the Health Insurance for the Aged [Medicare] Act. The district court held that the Secretary's regulation for recapture of accelerated depreciation charges, 20 C.F.R. § 405.415(a)(3) (1975) [sic], was unconstitutional as applied retroactively to the plaintiff. We hold that the district court had jurisdiction to

* Honorable Warren J. Ferguson, United States District Judge for the Central District of California, sitting by designation.

review the Secretary's action, but reverse on the merits.

I. FACTS

Under the Medicare Act, hospitals and similar institutions are reimbursed for providing services to eligible patients. Such "providers of services" are paid for their "reasonable costs," as defined in the statute and subject to regulations adopted by the Secretary, 42 U.S.C. § 1395x(v) (1970), *as amended* (Supp. IV, 1974).[1]

In 1967, Hazelwood Hospital began providing services under the Medicare program. The regulations then in effect allowed depreciation charges as an item of reasonable cost and provided that such charges could be computed by either a straight-line or an accelerated method.

On February 8, 1970, the Secretary announced a new regulation on depreciation. 35 Fed. Reg. 2593, *codified* at 20 C.F.R. § 405.415(d)(3) (1975). Effective August 1970, new providers were no longer allowed to claim accelerated depreciation. Old providers who remained in the Medicare program could con-

[1] The Medicare program is administered in part by private companies which act as agents of the Secretary in auditing cost data of hospitals and other institutions, so as to determine the amount they are paid for Medicare services. 42 U.S.C. § 1395h. In this case, the defendant Blue Cross of Oregon acted as the Secretary's fiscal agent. There is no dispute that Blue Cross simply followed the Secretary's regulation; thus the action is really one against the Secretary, named also as a defendant. *See* 20 C.F.R. § 405.670 (1975); Peterson v. Weinberger, 508 F.2d 45, 51-52 (5th Cir.), *cert. denied*, 423 U.S. 830 (1975).

tinue to use the accelerated depreciation method. Upon a provider's withdrawal from the program, however, the Secretary could recapture prior payments to the extent they were attributable to accelerated depreciation costs in excess of what would have been allowed under the straight-line method.[2]

In December 1971 Hazelwood voluntarily withdrew from the Medicare program. Its excess costs attributable to accelerated depreciation were $18,054 from 1967 through 1970, and $6,624 in 1970-71. Hazelwood rejoined the Medicare program in July 1972, and its subsequent reimbursements were reduced by a total of $24,678, to recapture the excess depreciation.

Hazelwood brought its suit in the district court, alleging federal question jurisdiction and claiming that 20 C.F.R. § 405.415(d)(3) could not be applied retroactively to recapture depreciation charges claimed for the years preceding its promulgation. The district court held that such application violated the due process clause of the fifth amendment. It enjoined the Secretary from applying the regulation to recapture

[2] The regulation provides as follows:

When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program . . . the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. 20 C.F.R. § 405.415(d)(3) (1975).

depreciation costs claimed by Hazelwood prior to January 1, 1970, and awarded Hazelwood a judgment for $18,054.

II. JURISDICTION

A. *The Medicare Statute and 28 U.S.C. § 1331*

The Medicare Act authorizes an individual beneficiary to obtain an administering hearing, and judicial review of a final decision, regarding either his eligibility or amount of benefits. 42 U.S.C. § 1395 ff(b) (1970), *incorporating id.* §§ 405(b), (g) *as amended* (Supp. IV, 1974). At the time this action arose, however, a provider of services (such as Hazelwood Hospital) was authorized to obtain review only of eligibility determinations. *Id.* § 1395 ff(c) (1970). No provision was made for review of the level of payments allowed to an institution under the "reasonable cost" standard.[3]

The Medicare Act is not unusual in providing specifically for judicial review of some but not all of the agency's decisions. In such cases the specific review provision is normally held to be the exclusive means of obtaining judicial review of the decisions for which it is available. The mere existence of such a mechanism for some matters, however, does not itself pro-

[3] The Social Security Act Amendments of 1972 changed this pattern so that payments to providers are now reviewable by a Provider Reimbursement Review Board, and ultimately by the district courts. 42 U.S.C. § 1395 oo (Supp. IV, 1974), *as further amended* (U.S.C.A. Supp. Mar. 1976). This change was not effective for accounting periods ending before June 30, 1973, and thus is unavailable for Hazelwood's challenge.

vide clear evidence of a congressional intent to preclude judicial review of the matters not covered. Thus such questions are normally subject to "non-statutory" review by a court having jurisdiction of the matter under one of the general provisions of title 28. *See* Note, *Jurisdiction to Review Federal Administrative Action: District Court or Court of Appeals*, 88 Harv. L. Rev. 980, 981-84 (1975).

The claim presented in this case is clearly not one for which the Medicare Act specifically authorizes judicial review. However, the plaintiff alleged—and the district court presumably found—federal question jurisdiction, 28 U.S.C. § 1331. While such jurisdiction would ordinarily be available for a question not reviewable under the special statutory procedure, the Medicare Act has incorporated the following addition provision of the Social Security Act:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under [28 U.S.C. § 1331, *inter alia*] to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h), *incorporated under id.* § 1395ii. In Weinberger v. Salfi, 422 U.S. 749, 761 (1975), the Court held that "the third sentence of § 405(h) precludes resort to federal question jurisdiction" for a

constitutional challenge to a denial of benefits under the Social Security Act. We conclude that this same language, incorporated into the Medicare Act, similarly precludes federal question jurisdiction in the instant case.

However, this conclusion does not end our inquiry. It is appropriate to consider possible bases for jurisdiction, even though not pleaded by the plaintiff or relied upon by the district court. Smith v. United States, 502 F.2d 512, 519-20 (5th Cir. 1974); Zimmerman v. United States, 422 F.2d 326, 330 (3d Cir.), *cert. denied*, 399 U.S. 911 (1970); *see* Williams v. United States, 405 F.2d 951 (9th Cir. 1969).

B. *The Administrative Procedure Act*

We have previously held that the judicial review provisions of the APA, 5 U.S.C. §§ 701-06, confer subject matter jurisdiction for district court review of reasonable cost determinations by the Secretary under the Medicare Act, 42 U.S.C. § 1395x(v). Rothman v. Hospital Service, 510 F.2d 956, 958-59 (9th Cir. 1975).[4] Thus we are bound to find jurisdiction

[4] The question of whether the APA generally confers jurisdiction for federal court review of agency decisions has not yet been answered by the Supreme Court and the circuits remain divided. This question normally arises where federal question jurisdiction is unavailable because of the amount-in-controversy requirement. One view is that the judicial review provisions of the APA are remedial and, like the Declaratory Judgment Act, apply only when the Court has otherwise obtained jurisdiction. *See, e.g.*, Zimmerman v. United States, 422 F.2d 326, 330-31 & n. 7 (3d Cir.), *cert. denied*, 399 U.S. 911 (1970); 13 C. Wright, A. Miller & E. Cooper, Federal Practice and Procedure § 3568 at 465-67 (1975). However, the increasingly prevalent view is that the APA embodies the

in the present case unless our holding in *Rothman* is affected by the Supreme Court's decision in *Weinberger* v. *Salfi, supra.*

The *Salfi* Court primarily construed the third sentence of section 405(h), which mentions only certain jurisdictional grants in title 28 and thus does not expressly include the APA, which is located in title 5.[5] At least three circuits have thus treated *Salfi* as irrelevant to the question of APA jurisdiction, interpreting its holding as limited to the effect of section 405(h) in precluding federal question jurisdiction.

presumption that agency action is normally subject to judicial review; thus it may be regarded as a basis for jurisdiction when other jurisdictional statutes are unavailable. *See, e.g.,* Pickus v. United States Board of Parole, 507 F.2d 1107, 1109-10 & n. 4 (D.C. Cir. 1975), and cases cited therein; Byse & Fiocca, *Section 1361 of the Mandamus and Venue Act of 1962 and "Non-statutory" Judicial Review of Federal Administrative Action,* 81 Harv. L. Rev. 308, 326-31 (1967). Our circuit has adopted the latter position. Wiren v. Eide, No. 74-1169 (9th Cir. June 22, 1976) (slip opinion); Rothman v. Hospital Service, 510 F.2d 956, 958 (9th Cir. 1975); Brandt v. Hickel, 427 F.2d 53, 55 (9th Cir. 1970); Washington v. Udall, 417 F.2d 1310, 1319-20 (9th Cir. 1969) *(semble);* Coleman v. United States, 363 F.2d 190, 193 (9th Cir. 1966), *rev'd on other grounds,* 390 U.S. 599 (1968).

[5] At the time § 405(h) was originally enacted in 1935, this sentence referred to all of the general grants of jurisdiction then available to a district court. It has not been amended since, and thus does not include the more recent jurisdictional provisions of the federal mandamus statute, 28 U.S.C. § 1361, or the APA. One could suggest that § 405(h) should have the same effect now as when it was enacted and thus be extended to preclude review under these newer jurisdictional statutes. On the other hand, Congress has not amended § 405 (h) in th same manner as 38 U.S.C. § 211(a), which now provides for certain decisions of the Veterans' Administrator that "no other official or any court of the United States shall have power or jurisdiction to review any such decision *by an action in the nature of mandamus or otherwise*" (italicized language added in 1970).

Hunt v. Weinberger, 527 F.2d 544, 546-47 (6th Cir. 1975); Lejeune v. Mathews, 526 F.2d 950, 952-53 & n.2 (5th Cir. 1976); Sanders v. Weinberger, 522 F.2d 1167, 1171 (7th Cir. 1975).

However, we do not think this a proper basis for distinguishing the Court's decision. The plaintiffs in *Salfi* (unlike the instant plaintiff) expressly alleged jurisdiction under the APA. Appendix at 7, *Weinberger* v. *Salfi, supra; see* Brief for Appellees at 42-43. And, in ordering dismissal on the class of unnamed plaintiffs who had not complied with the jurisdictional prerequisites of section 405(g), the Court held that "[o]ther sources of jurisdiction [are] foreclosed by § 405(h)." 422 U.S. at 764. Thus the Court must have regarded APA jurisdiction as either precluded by section 405(h)[6] or unavailable for some other reason.[7]

[6] Although the third sentence of § 405(h) does not mention the APA, the *Salfi* Court interpreted the first two sentences of that section as "prevent[ing] review of decisions of the Secretary save as provided in the Act." 422 U.S. at 757-58; *see id.* at 759 n. 6. This interpretation would seem to apply to the APA as much as to 28 U.S.C. § 1331. In *Rothman* we acknowledged the second sentence of section 405(h) might be read to prevent judicial review of questions not specifically made reviewable under the Act. Instead, however, we viewed this sentence as simply preventing a claimant from bypassing the statutory procedures in those matters for which they were available. 510 F.2d at 958-59. Our interpretation of § 405(h) may be somewhat inconsistent with the above-cited language in *Salfi,* but not with the Court's holding. As we discuss *infra,* review under the Social Security Act was available to the plaintiffs dismissed in *Salfi.* 422 U.S. at 762-64.

[7] Of course, it is not clear that the Court accepts the view that the APA can provide jurisdiction. *See* note 4 *supra.* Alternatively, the Court could view APA jurisdiction as available only in the "absence or inadequacy" of a special statu-

There is, however, a well supported and important distinction between *Salfi* and the instant case. There the Social Security Act authorized district court review of all final decisions of the Secretary, under the procedures specified in section 405(g). Thus judicial review was potentially available to the class of unnamed plaintiffs, and the Court's holding did not have the effect of totally precluding judicial review of the sort of claim they raised. Additionally, the Court qualified its holding in a respect that is important in distinguishing this case. The Court noted that where a constitutional claim is presented, statutes are not likely to be interpreted to preclude judicial review altogether. 422 U.S. at 762-63.

In contrast to the Social Security Act interpreted in *Salfi*, the Medicare Act (prior to 1972) did not authorize judicial review of provider payment claims. Then, interpreting section 405(h) to preclude all review outside of the Act, would foreclose any judicial inquiry even in cases containing significant constitutional questions, such as the hospital's claim in this case. Under these circumstances, we conclude that *Salfi* does not control the present case and follow our decision in *Rothman*. Thus we regard the district court as having jurisdiction by virtue of the judicial review provisions of the APA.

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tory review procedure. 5 U.S.C. § 703; *see id.* § 704. Thus the APA would not have been a potential basis for jurisdiction, since § 405(g) was available to the unnamed plaintiffs in *Salfi*. *See* 422 U.S. at 764.

III. STATUTORY AUTHORITY

The district court made no express ruling on the plaintiff's contention that the Secretary lacked statutory authority to promulgate the regulation here in question. We assume, however, that it would not have reached the constitutional issues in this case if the regulation could have been invalidated on a statutory basis. *See* Ashwander v. TVA, 297 U.S. 288, 348 (1936) (Brandeis, J., concurring). We agree with the implicit holding of the district court that the regulation was a valid exercise of the authority delegated the Secretary under the Act.

42 U.S.C. 1395hh authorizes the Secretary to promulgate necessary regulations, and *id.* § 1395x(v)(1)(A) specifically authorizes regulations "establishing the method or methods to be used and the items to be included," in calculating the reasonable cost of providing Medicare services. The way in which an institution computes depreciation as an element of its costs clearly is an appropriate subject for regulations adopted pursuant to this statutory authority.

The hospital here contends that the recapture of its depreciation is not a "suitable retroactive corrective adjustment" and thus prohibited by *id.* § 1395x(v)(1)(A)(ii). This provision of the statute states that regulations governing costs shall:

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of de-

termining costs proves to be either inadequate or excessive.

Hazelwood argues this limits the Secretary's rulemaking power to corrective adjustments that are retroactive for one fiscal year, but no longer; therefore, it argues, none of its pre-1970 depreciation is subject to recapture. This is untenable.

First, this statute commands the Secretary to make retroactive adjustments in certain cases, but it does not declare that the Secretary is limited to that power. Second, we do not accept an interpretation of the statutory term "any fiscal period" as a limitation on the time in which the Secretary may initiate an adjustment. The term seems more logically to define the time span over which an inadequate or excessive reimbursement may be deemed to have occurred. Thus we conclude that 20 C.F.R. § 405.415(d)(3), as applied to Hazelwood Hospital, was within the Secretary's statutory authority.

IV. CONSTITUTIONALITY

The district court held that it was a violation of the due process clause for the Secretary to apply 20 C.F.R. § 405.415(d)(3) to recapture any depreciation charges allowed prior to the calendar year in which the regulation was promulgated. We disagree.

The due process clause does not make unconstitutional every law with retroactive effect. Almost all new laws upset some expectations, and frequently

changes are made in the legal consequences of prior conduct. Only when such retroactive effects are so wholly unexpected and disruptive that harsh and oppressive consequences follow, is the constitutional limitation exceeded. *See, e.g.*, Welch v. Henry, 305 U.S. 134, 146-51 (1938).

The retroactive effects of the instant regulation were limited and reasonable. Its operation was triggered by a subsequent act: withdrawal from the Medicare program. If Hazelwood Hospital had remained in the program there would have been no recapture of the accelerated depreciation. Indeed, the regulation was given further prospectivity by its grandfather clause, allowing providers who had previously used the accelerated depreciation method to continue doing so, as long as they remained in the program. The regulation, moreover, was not made effective until nearly six months after promulgation. Hazelwood made no attempt to leave the program during this time, when it might have avoided the recapture provision.[8]

We view the regulation in this case as particularly reasonable since it is part of the ongoing adjustment necessary in a program of distributing federal subsidies. Here the government is not directly regulating a purely private activity. Hazelwood Hospital volun-

[8] It is true that the Secretary could have required as much as six months' notice before releasing Hazelwood from the program. 20 C.F.R. § 405.613 (1970). Thus Hazelwood might not have been successful had it tried to avoid the recapture regulation by withdrawing prior to the effective date. However, Hazelwood made no such attempt and has not shown that it would have been likely to fail in making such a withdrawal.

tarily entered, and indeed re-entered, this program as a provider of services in return for reimbursement from the government. Under the statute, it was entitled to be paid for its "reasonable costs," an admittedly imprecise concept, in an amount to be determined under regulations promulgated by the Secretary. The regulation here in question was a valid exercise of the Secretary's authority under the statute. "Those who do business in the regulated field cannot object if the legislative scheme is buttressed by subsequent amendments to achieve the legislative end." FHA v. The Darlington, Inc., 358 U.S. 84, 91 (1958).

Accordingly, we reverse the judgment of the district court and remand for entry of judgment in favor of the defendant Secretary.

FERGUSON, District Judge, concurring and dissenting:

I concur in the result reached by the majority on the jurisdictional issue, but must dissent from its decision on the merits.

42 U.S.C. § 1395(g) requires the Secretary to "periodically determine" the "amount which should be paid" to a provider of services. Pursuant that requirement, the Secretary issued a regulation providing that "*final* settlement" would be "at the end of the accounting period." 20 C.F.R. § 405.405(c) (emphasis added).

After an exhaustive analysis of the statutory scheme emphasizing the above cited provisions, the

court in *Mount Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 376 F. Supp. 1099, 1129 (S.D. Fla. 1974) concluded that the retroactive cost adjustment procedure authorized by 42 U.S.C. § 1395 x (u)(1) [sic] is "limited by its terms to 'any fiscal period,'" and that the Secretary in his regulations has limited retroactivity to the " 'end of the accounting period.' " *Id.* Although the fifth circuit did not accept other portions of the district court's opinion, it specifically approved its analysis regarding retroactive cost adjustments: "The District Court's opinion on [the procedure with respect to cost determinations] correctly analyzes the statutory scheme . . . Congress chose to pay providers only the 'reasonable cost' of services, *to be determined at the end of each fiscal year.*" *Mount Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F.2d 329, 335 (5th Cir., 1975), *cert. denied*, 44 U.S.L.W. 3589 (U.S. Apr. 19, 1976). *But see Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973).

Congress required the Secretary to *determine* the amount which should be paid, and he did. Congress did not countenance a procedure which would permit the Secretary at any time to reopen final determination as to cost. I would follow the analysis pursued in the fifth circuit and affirm the district court's decision.

42 U.S.C. § 1395x(v)(1)(A), 42 U.S.C.A. pp. 493-4 (1974) provides as follows:

"The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipient of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the ef-

ficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecesasry in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

20 C.F.R. § 405.415(d)(3), 20 C.F.R. p. 459 (1976) provides as follows:

> "When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years."

I hereby certify that service of the foregoing Petition for Certiorari was made on the parties hereto by placing three certified true copies of said Petition for Certiorari in the United States Post Office at Portland, Oregon, mailed prepaid postage "Airmail Special Delivery," on December 17, 1976, addressed to each of the following:

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No. 76-859

In the Supreme Court of the United States

OCTOBER TERM, 1976

HAZELWOOD CHRONIC & CONVALESCENT HOSPITAL, INC., d/b/a KEARNEY STREET CONVALESCENT CENTER, PETITIONER

v.

JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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In the Supreme Court of the United States

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HAZELWOOD CHRONIC & CONVALESCENT HOSPITAL, INC., d/b/a/ KEARNEY STREET CONVALESCENT CENTER, PETITIONER

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BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the district court is not reported (Pet. App. A1-A7). The opinion of the court of appeals (Pet. App. A8-A21) is reported at 543 F. 2d 703.

JURISDICTION

The judgment of the court of appeals was entered on September 23, 1976. The petition for a writ of certiorari was filed on December 22, 1976. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTION PRESENTED

Whether the Secretary may, by regulation, provide for the recovery of excess depreciation taken by a provider of services who leaves the Medicare program.

STATUTE AND REGULATION INVOLVED

The pertinent statutory and regulatory provisions are set forth at Pet. App. A22-A24.

STATEMENT

Part A of Subchapter XVIII of the Social Security Act, as added, 79 Stat. 291, and amended, relating to the Medicare program, 42 U.S.C. (1970 ed. and Supp. V) 1395c to 1395i-2, is designed to provide basic protection against the costs of hospital services for eligible aged or disabled individuals. 42 U.S.C. (Supp. V) 1395c. Participating hospitals, the providers of medical services paid for by the Medicare program, do not charge Medicare patients directly but instead are reimbursed by the Secretary of Health, Education, and Welfare. 42 U.S.C. (and Supp. V) 1395i, 1395cc. The providers are entitled to reimbursement for all "reasonable costs" actually incurred in connection with furnishing hospital services to Medicare beneficiaries. 42 U.S.C. (Supp. V) 1395f(b), 1395g. "Reasonable costs" are to be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs. 42 U.S.C. (Supp. V) 1395x (v)(1)(A). Such regulations may provide for suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive. 42 U.S.C. (Supp. V) 1395x(v)(1)(A)(ii).

A provider is reimbursed on an interim, pre-audit basis not less often than monthly, based upon billings submitted to the Secretary that are determined by the latter, on the basis of the information then available to him, to constitute the "reasonable cost" of providing services covered under the Act. 42 U.S.C. (Supp. V) 1395g. At the close of the provider's fiscal year, it submits a cost report, and the

Secretary then determines by audit the actual amount of reimbursement to which the provider is entitled for that year. 20 C.F.R. 405.451(b)(1). If it is determined that the interim payments were more or less than the amount to which the provider is entitled, an adjustment may be made in the current interim payments to the provider in order to recoup or repay the difference involved. 42 U.S.C. (Supp. V) 1395g; 20 C.F.R. 405.454.

Among the reimbursable costs to providers is depreciation of their assets. Prior to August 1, 1970, providers were entitled to compute depreciation charges by means of either the "straight-line" or the "accelerated" method. See 20 C.F.R. 405.415 (1970). On August 1, 1970, a new regulation, first proposed by the Secretary on February 5, 1970 (35 Fed. Reg. 2593) became effective. 35 Fed. Reg. 12330. This regulation, now 20 C.F.R. 405.415, provides that the accelerated method of depreciation can be utilized by providers for assets acquired after August 1, 1970, only in certain limited circumstances. 20 C.F.R. 405.415(a)(3)(ii), (iii). In addition, the regulation states that if a provider that utilized the accelerated method of depreciation terminates its participation in the program, the excess of reimbursable cost paid utilizing the accelerated depreciation methods, over the reimbursable cost which would have been determined and paid using the straight-line method, will be recovered as an overpayment received by the provider during its participation in the program. 20 C.F.R. 405.415(d)(3).

The purpose of the amendment was to make an adjustment, as required by 42 U.S.C. (Supp. V) 1395x (v)(1)(A)(ii), to prevent excessive reimbursements. If such an adjustment were not made, providers that leave the Medicare program after utilizing the accelerated method for less than the estimated life of the asset would have received a

greater total reimbursement than if they had utilized the straight-line method of depreciation for the same period. See *Springdale Convalescent Center* v. *Mathews*, 545 F. 2d 943, 953-954, 956 (C.A. 5).

Petitioner was a provider under the Medicare Program from 1967 until December 1971, and had been reimbursed for depreciation on the basis of the accelerated method. When petitioner withdrew from the program, the fiscal intermediary, which handles the day-to-day administration of the program for the Secretary (42 U.S.C. (and Supp. V) 1395h), determined that use of the accelerated method of depreciation had provided petitioner with $24,678 more in reimbursement than it would have received had the straight-line method been used. By the time this determination had been made, petitioner had rejoined the Medicare program, and the intermediary sought to recover the excess payments by reducing the monthly reimbursements currently being made to petitioner.

Petitioner filed this action in the United States District Court for the District of Oregon, seeking a declaratory judgment that the regulation providing for recapture of accelerated depreciation was not authorized by statute and was unconstitutional, a permanent injunction against enforcement of the regulation, and recovery of the amounts that had been withheld from petitioner pursuant to the regulation. The district court held that the regulation denies due process insofar as it authorizes recapture of reimbursement for depreciation charges taken prior to the beginning of the year in which it was promulgated (Pet. App. A6-A7). The court further held, however, that the regulation was valid as applied to depreciation charges taken after December 1969 (Pet. App. A7). The court enjoined the Secretary from applying the regulation to petitioner for the period preceding January 1, 1970, and awarded a money judgment for the amounts that had been withheld with respect to the period prior to that date.

On the government's appeal,[1] the court of appeals reversed and remanded for entry of judgment in favor of the Secretary (Pet. App. A8-A20). The court held that the district court had correctly asserted jurisdiction to hear the case under the Administrative Procedure Act, 5 U.S.C. 701 *et seq.* (Pet. App. A13-A16). But the court of appeals further held that the regulation was a valid exercise of authority under the Act, reasoning that 42 U.S.C. (Supp. V) 1395x(v)(1)(A)(ii) authorizes suitable retroactive corrective adjustments of the kind made here (Pet. App. A17-A18). The court of appeals also rejected petitioner's contention that the regulation denies due process.

DISCUSSION

1. The regulation permitting recapture of excess depreciation charges is reasonable and was correctly sustained by the court of appeals. Accelerated and straight-line methods of depreciation each allocates the entire cost of an asset over its useful life; a provider who continues in the Medicare program for the useful life of a facility would, over time, receive the same reimbursement for depreciation under either method of accounting. But providers who elect to be reimbursed on the basis of the accelerated method of depreciation and then withdraw from the Medicare program during the useful life of the facility will have received inflated reimbursements, because the accelerated method permits a disproportionate percentage of the cost of an asset to be charged off during the earlier years of the asset's life. The regulation providing for the recapture of the reimbursements attributable to the amount by which accelerated depreciation exceeded straight-line depreciation serves the permissible purpose of preventing such

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[1]Petitioner did not appeal from that portion of the judgment of the district court adverse to it.

providers from retaining the inflated portion of their reimbursements.[2] This result is authorized by the statutory delegation to the Secretary of the responsibility for determining the providers' actual "reasonable costs" and making retroactive adjustments. 42 U.S.C. (Supp. V) 1395x(v).[3]

a. Petitioner incorrectly contends (Pet. 10-16) that the Secretary's statutory authority to provide for retroactive adjustments relates only to current fiscal periods. The statute expressly states that the Secretary is authorized to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services *for any fiscal period*, the aggregate reimbursement produced by the methods of determining costs proves to be * * * excessive." 42 U.S.C. (Supp. V) 1395x(v)(1)(A)(ii) (emphasis added).[4]

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[2]Petitioner complains (Pet. 13-14) that the regulation does not affect all providers. It did not have to. The Secretary's regulation pertained to a particular "method[ ] of determining costs" (42 U.S.C. (Supp. V) 1395x(v)(1)) employed only by some providers. The correction provided by the regulation extended only to those among that group of providers as to whom the method had produced excessive reimbursement over the period during which the asset subject to depreciation was used in the Medicare program. This was fully consistent with the statute, which permits "suitable retroactive corrective adjustments" where reimbursements produced by "the methods of determining costs" prove excessive (*ibid.*).

[3]Contrary to petitioner's claim (Pet. 13), the Secretary was not required to publish specific findings before promulgating the recapture regulation. See *Pacific States Box & Basket Co.* v. *White*, 296 U.S. 176, 185-186. Furthermore, ample opportunity for public comment on the factual basis of the regulation was provided during the 6 months between publication of the proposed regulation and final promulgation.

[4]In contending that only current adjustments are permitted, petitioner relies (Pet. 11-12, n. 7) upon legislative history that relates to adjustments made to rectify overpayments or underpayments in the interim payments that are made during the course of a single fiscal year under 42 U.S.C. (Supp. V) 1395g, not to retroactive adjustments made under 42 U.S.C. (Supp. V) 1395x(v). See Hearings on Reimbursement Guidelines for Medicare, before the Senate Committee on Finance, 89th Cong., 2d Sess. 119-120 (1966).

That statutory language plainly anticipates that retroactive adjustment can be made in past fiscal periods, and it places no limitation on how distant in time those periods may be; it specifically permits adjustment to be made with respect to "any fiscal period."[5]

b. The recapture regulation challenged by petitioner has been sustained by every court of appeals that has considered it. In addition to the court below, the First and Fifth Circuits also have upheld the regulation. *Adams Nursing Home of Williamstown, Inc.* v. *Mathews*, No. 76-1212, decided February 2, 1977 (C.A. 1); *Springdale Convalescent Center* v. *Mathews, supra.*

Petitioner's assertion to the contrary (Pet. 8-9) notwithstanding, there is no conflict. The recapture regulation was not at issue in the cases upon which petitioner relies. Moreover, the courts in *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F. 2d 663, 669 (C.A. 2), and *Whitecliff, Inc.* v. *United States*, 536 F. 2d 347, 352 (Ct. Cl.), petition for a writ of certiorari pending, No. 76-1188, held that the statute not only permits but requires the Secretary to make retroactive corrective adjustments to past fiscal years; those courts therefore almost certainly would have sustained this regulation if it had been before them.[6]

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[5]Petitioner's suggestion (Pet. 12) that the Fifth Circuit reads the statute as limiting readjustments to the immediately preceding year is incorrect. That court has expressly repudiated any such reading. *Springdale Convalescent Center* v. *Mathews, supra*, 545 F. 2d at 953 n. 9, 954.

[6]Although the Fifth Circuit in *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F. 2d 329, 335 (C.A. 5), certiorari denied, 425 U.S. 935, suggested in *dictum* that adjustments might be limited to the immediately preceding fiscal year, that *dictum* was disapproved in *Springdale Convalescent Center* v. *Mathews, supra*, 545 F. 2d at 953 n. 9, 954. The regulation challenged here was sustained in *Springdale Convalescent Center;* it was not at issue in *Mt. Sinai Hospital of Greater Miami.*

2. Petitioner further contends (Pet. 16-19) that the operation of the recapture regulation denies due process. The court of appeals correctly rejected this contention. See also *Springdale Convalescent Center* v. *Mathews, supra; Adams Nursing Home of Williamstown, Inc.* v. *Mathews, supra.*

At the time petitioner voluntarily undertook the responsibilities of a provider of Medicare services, it was on notice that the statute authorized retroactive adjustments in payments to the extent necessary to correct excessive reimbursements. Petitioner therefore cannot claim that it was unfairly surprised by the Secretary's proposal to promulgate regulations providing for such adjustments. Cf. *Welch* v. *Henry,* 305 U.S. 134, 149-150. Furthermore, petitioner had notice of the proposal approximately six months before the regulation was promulgated; if during that time petitioner had concluded that the conditions to be imposed by the regulation were unduly onerous, petitioner could have withdrawn from the Medicare program. Since petitioner did not attempt to withdraw (Pet. App. A19), but rather voluntarily continued in the program with knowledge of the terms governing its participation, including the recapture regulation, it cannot be said that the subsequent application of that regulation to petitioner was so harsh or oppressive as to deny due process. See *Chase Securities Corp.* v. *Donaldson,* 325 U.S. 304, 315-316.

3. The judgment of the court of appeals has an alternative basis. The court acknowledged that jurisdiction under 28 U.S.C. 1331 was barred in this case by 42 U.S.C. 405(h) (Pet. App. A11-A13).[7] But the court concluded that jurisdiction

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[7]The question whether 42 U.S.C. 405(h) bars review of provider reimbursement disputes is now before this Court in *United States* v. *Whitecliff, Inc.*, petition for a writ of certiorari pending, No. 76-1188. But since the courts below asserted jurisdiction and disposed of petitioner's claims on the merits and, for the reasons set forth above (pp. 5-8, *supra*), those claims do not themselves warrant review, this case need not be held pending disposition of *Whitecliff.*

was conferred by the Administrative Procedure Act (Pet. App. A13-A16). That conclusion was erroneous. *Califano* v. *Sanders,* No. 75-1443, decided February 23, 1977. Accordingly, the courts below appear to have lacked jurisdiction to consider this case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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DOJ-1977-03

In the Supreme Court

of the United States

OCTOBER TERM, 1976

No. 76-859

HAZELWOOD CHRONIC & CONVALESCENT HOSPITAL, INC., dba KEARNEY STREET CONVALESCENT CENTER,

Petitioner,

v.

JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION AND WELFARE, THE UNITED STATES OF AMERICA, and BLUE CROSS OF OREGON, dba NORTHWEST HOSPITAL SERVICE,

Respondents.

PETITIONER'S REPLY BRIEF

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PETITIONER'S REPLY BRIEF

NEW ARGUMENTS STATED

1. *The "question presented."* Respondents' statement of the question (Resp. 1) predicts their insertion of new issues and non-issues. The issues were framed in the Petition (Pet. 2-3); they are of statutory construction and constitutional authority. Of course, "excess depreciation" given by Medicare may, by regulation, be taken back by Medicare. But what is "excess"? How may that be determined? What authority allows the respondents to act without that de-

termination? And what limitation is there on such action, aside from caprice?

2. *Findings.* The respondents first imply (Resp. 3-4) that the Secretary found and determined the economic method for calculating what the statute requires — "costs actually incurred." Then the respondents urge, albeit obliquely, (Resp. 6, fn. 3) that the Secretary need not make such findings. These arguments are, respectively, factually false and legally wrong.

3. *Economics.* The respondents argue (Resp. 6) that petitioner received "inflated" reimbursements. The argument fails on any economic analysis.

4. *Jurisdiction.* The government here contends (Resp. 8-9) that there has been no jurisdiction in this case, but this Court need not say so, respondents add. In *U. S.* v. *Whitecliff, Inc.*, cert. pending (No. 76-1188), however, this month, the government urges the Court to assume jurisdiction to block retroactive Medicare adjustment review.

FINDINGS

Respondents imply (Resp. 3-4, 5-6) that the Secretary made findings. If he did, they certainly have not been articulated anywhere. Respondents argue (Resp. 6, fn. 3) that the regulation in question, however, did not need findings to undergird the regulation. It must be tested, at law, by the enabling legislation, which requires two measurements for reimbursement regula-

tions: (1) any method of computing a reimbursable item must approximate the "cost actually incurred" in providing that item for Medicare purposes (42 U.S.C. § 1395x(v)(1)(A), Pet. App. A22), and (2) reimbursements from Medicare sources cover only the actual costs of providing Medicare services (42 U.S.C. § 1395x(v)(1)(A)(i), Pet. App. A22).

Here, presumptions will not suffice. Congress required that findings and determinations be made to support regulations on "cost actually incurred." Congress specifically included a limitation that a retroactive corrective regulation is authorized *only* if, for any fiscal period, a method of computing costs *proves (viz,* is proven) to yield excessive (that is, higher than actual cost) reimbursements (Pet. App. A23). Congress would not have required a useless act; if a presumption that the specific prerequisite findings have been made can be bootstrapped *ipso facto* from the adoption of the recapture regulation, Congress' requirement of findings-proof is a nullity.

ECONOMICS

Respondents urge (Resp. 6, fn. 2) that the challenged regulation is carefully tailored to affect only those providers whose accelerated depreciation reimbursements were "excessive." Not so. Contrary to respondent's' implication (Resp. 3), the regulation is applied to label as receivers of "excessive" reimbursements only those providers who used accelerated depreciation and terminated after August 1, 1970 —

not providers who took those exact same depreciation charges and terminated before August 1, 1970. Those pre-August terminators received aggregate depreciation reimbursements more in excess of the cumulative straight-line depreciation totals than did post-August terminators such as petitioner. Yet respondents would have this Court believe that only post-August terminators received "excessive" reimbursements. If the vice behind "excessive" Medicare payments is that those surplus amounts are used to subsidize non-Medicare expenses in violation of the statutory guideline,[1] then the pre-August terminators are the most serious violators of the Congressional mandate. Yet the Secretary by implication has not deemed these providers to have received excessive reimbursements. Respondents' arguments defy logic, common sense and close analysis.

A retroactive adjustment regulation is textually authorized where a reimbursement regulation has created excessive total reimbursements for a particular period. It is elementary that an excessive "total reimbursement" cannot have occurred unless the initial reimbursement regulation failed to approximate the actual economic cost of providing Medicare services. Nowhere is there a finding that accelerated depreciation does not approximate actual economic cost of fixed asset utilization, or that straight-line does. The patent justification behind the challenged regulation is fiscal rather than economic: regardless of whether

[1] And that *is* the statutory mandate, see Pet. App. A22.

accelerated depreciation approximates actual asset cost, straight-line reimbursements involve lesser expenditures, in a shorter period of time than the useful life of the asset. But of what value is that economic fact? Congress chose a standard of approximating "actual cost" rather than a standard yielding the least economic reimbursement. The Secretary did not follow this standard.

Whether the previously-validated accelerated depreciation method yielded amounts higher than actual economic asset depletion — whether over one fiscal program period or over the entire useful life of the asset, is an economic question to which some answer could be found. That accelerated depreciation is not straight-line depreciation is no answer. Nor is a focus on temporary termination of participation in the Medicare program any economic answer, although such a focus could be a punitive "answer," born of revenue needs.[2]

JURISDICTION

Respondents' soothing suggestion (Resp. 8, fn. 7) that *United States* v. *Whitecliff, Inc.* raises issues identical to the present petition supports rather than discourages acceptance of the present petition. In that case (536 F.2d 347, Ct. Cl. 1976) the government

[2] Respondents lightly pass off (Resp. 8) the prospect that petitioner could have withdrawn from the program before the effective date of the retroactive regulation. The Secretary held the withdrawal rights, not the petitioner. See 20 C.F.R. § 405.613 (1970).

argued that it never should take retroactive action, even if a provider had been inadequately reimbursed for "cost actually incurred." Moreover, respondents there argued that no court should review such determination of the Secretary. In urging this Court now to accept certiorari in *Whitecliff* (No. 76-1188, cert. pending) the government argues that there is a jurisdictional issue worthy of this Court's attention.

In our case, however, the respondents urge that no jurisdictional issue is of similar worth — although it is the same issue. The respondents' reliance on *Califano* v. *Sanders* (Resp. 9) is misplaced. Rather than precluding Administrative Procedure Act jurisdiction for claims of the type presented by this petitioner, *Califano* recognizes that the Constitutional (and, by the same logic, the statutory) challenges raised by petitioner are the precise type of issues for which APA jurisdiction does lie. Supreme Court Docket No. 75-1443, 45 U.S. L. W. 4209, 4211 (Decided 2/23/77). Moreover, there are adequate other jurisdictional grounds here. See *Rhodes* v. *Weinberger*, 388 F.S. 437 (D.C. Pa. 1975) (28 U.S.C. § 1361 provides jurisdiction to compel the Secretary to cease enforcing an unconstitutional provision); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 292 (8 Cir. 1976) (28 U.S.C. § 1331 provides jurisdiction to review a provider's claim of denial of constitutional rights).

CONCLUSION

The issues raised in the instant petition for certiorari are of widespread and growing concern within all levels of lower federal courts. The petition for a writ of certiorari should be granted.

Respectfully submitted,

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